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HEALTH OF THE URBAN POOR

Prepared for the Second National Health Assembly (NHA-2)

Bhopal, Madhya Pradesh

Work in progress

This section is to be included in a booklet on 'Defending the Right to Health for Various Sections of the Indian people!' In case you have any suggestions, please contact

Mr. Chander, Community Health Cell, (chander@sochara.org).

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HEALTH OF THE URBAN POOR

27.8% of India's total population lives in urban areas. That means 285 million urban citizens, as many people as there are in the United States totally. There are 4,000 cities and towns in India. About 300 cities have population over 1, 00,000. Seven cities have population more than 3 million.

31% of the urban population is poor *(Source : Census 2001)*

Urban poor in India will be 200 million by 2025.

Who are the urban poor?

Urban India is a study in contrasts: it contributes 60% of the country's national income. But 76 million urban Indians live below the poverty line, 21% of the urban population lives in slums, and 60% work in the unorganized sector, without any kind of social security (Source: http://infochangeindia.org/urban_india.jsp).

Urban poor include day laborers, domestic helpers, small service providers, drivers, riksha pullers, hairdressers, vendors, beggars, street children etc. Some, however, work in factories or even as government employees at lower levels with wages that barely meet their needs. Most of them have migrated from villages in search of employment opportunities.

Rural poverty and urbanization

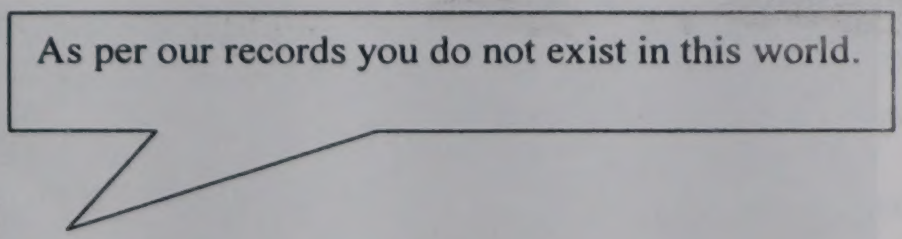
Rural poverty is forcing millions of people from rural areas to migrate to urban areas in search of subsistence for their livelihood. When they reach the urban areas, the only place which is available for them to make their habitation is the already over crowded slums located in most places unfit

human habitation, lacking the basic amenities. In many cases they young population of rural areas have to leave behind the elderly to the care of the elderly themselves. Migration is influenced by pattern of development and social structure. The national commission on rural labour reported that uneven development was the main cause of seasonal migration. The migration of rural population to urban areas has made cities densely populated.

Identity crisis of the Urban Poor

The estimates of urban poor do not reflect the true magnitude, as significant proportion of urban poor is "un-accounted" for as they stay in unrecognized squatter-settlements, pavements, constructions sites, urban fringes, etc. Many of them lack basic documents of citizenship identity like their name in the voters list, ration card etc. Their births and deaths are often not registered. National data such as the census, sample survey most often do not include them there by making no information available for planners to plan any service for them. They are denied of basic services for want to proper identity.

More than half of those living in urban slums had been living there for more than 15 years. About 20% had moved in during the previous five years. About 30% used to stay in a village before coming to the slum. About 20% slum households did not possess any document like ration card or voter ID-card.
(Source: National Sample Survey Organization, ministry of statistics and programme implementation, (July – December 2002)



STREET CHILDREN

Who are they?

Children who live or work on the streets. Some of these children live with their families (who are also living on the streets). Other street children live and work on the streets but do not live with their families. The term can also include child labourers, sexually-exploited children, and war-affected children, who may also be forced to live or work on the street. (Source: http://www.acdi-cida.gc.ca/CIDAWEB/acdicida.nsf/En/REN-218125542-Q3B)

UNICEF's estimate of 11 million street children in India in 1994 is considered to be conservative. Estimated 100,000 – 125,000 street children each in Mumbai, Kolkata and Delhi, with 45,000 in Bangalore.

Constraints

- Lack of birth registration, uniform adoption law, children's participation and child-centred approaches in government.
- Inadequacy of budget allocation impacts on sustainability of projects and, in particular, the ability to employ qualified and experienced social workers.

Problems

Street children are subject to malnutrition, hunger, health problems, substance abuse, theft, CSE, harassment by the city police and railway authorities, physical and sexual abuse.

Interventions recommended

- Community-based models with an emphasis on the contact / outreach programme as against the old approach juvenile justice system (institutionalizing street children in custodial care)
- Group approach versus the individual approach as street children always stay in groups.
- Launch Railway Children intervention
- Link street children into urban poverty reduction programmes.
- Increased emphasis on HIV/AIDS awareness programmes
- community-based models, night shelters, drop-in / contact centres in the vicinity of places of work/stay of street children, innovative models of NGOs with *Bal Mandals* (Children's Committees), and children's participation in decisionmaking.
- Implementation and enforcement of the 2000 Juvenile Justice Act throughout the country.
- Amendment to Child Labour (Prohibition and Regulation) Act 1986 to protect children (particularly street children) in informal labour economy. Simplification of procedures to obtain grant-in-aid from the government to reduce the burden of paperwork.

- Timely release of government grants, allocation of adequate funds on a long-term basis, continued financial support to ensure sustainability of NGO interventions and beneficiary rather than donor-led funding policies.
- Realistic appraisal of the situation of street children to acknowledge the current inadequacy of government and NGO interventions to reach such a vast number of children in major cities in India.

Source: report of the "A Civil Society Forum for South Asia on Promoting and Protecting the Rights of Street Children", 12- 14 December 2001, Colombo, Sri Lanka.

DETERMINANTS OF URBAN HEALTH

Poverty

The vicious cycle between poverty and ill health is well documented by many studies. Constant ill health further impoverishes the poor. Unless the cycle is broken the chances of the poor enjoying the basic health will continue to be in jeopardy.

> **Over 400 million people in India live below the internationally agreed poverty line (living on less than US $1 per day). This is one in three of the worlds poorest.** *(http://www.ukinindia.com)*

The World Bank's definition of the poverty line, for under developed countries, like India, is US$ 1/day/person or US $365 per year, as per this definition, more than 75% of all Indians are, probably, below the poverty line!. Poverty in India can be defined as a situation only when a section of peoples are unable to satisfy the basic needs of life. According to an expert group of Planning Commission, poverty line in rural areas is drawn with an intake of 2400 calories in rural areas and 2100 calories in urban areas. If

the person is unable to get that minimum level of calories is considered as being below poverty line. (source:http://www.indiatogether.org/2003/sep/pov-upairev.htm)

Malnutrition

Malnutrition is a common problem where the poverty status is constant. Poverty status of families affects the Children more. Based on re-analysis of National Family Health Survey 2 (1998-99) data by Standard of Living Index, 56.8% of less than 3 years old children (about 4.5 million), among the urban poor are malnourished. Poor living environment further adds to health challenges of slum dwellers: Inadequate sanitation, hygiene and water are a predominant feature of urban slums which results not only in more sickness and death but also in higher health costs, lower school enrollment and retention rates and lower work productivity. Poor living environment in urban slums therefore, calls for greater attention of service providers and coordinated action by the Integrated Child Development Services (ICDS) and other concerned departments. (Source: http://www.uhrc.in)

Another concern area is the availably of food grain. The population has increased from about 36 crores in 1951 to 103 crores in 2001. Despite the food grain production going up from 175 million tonnes in the 1980s to 206 million tonnes in the 1990s, the growth rate in the per capita availability of food grains has come down. The planning commission also has observed that that food consumption by the poor has gone down in the last 10 years. No wonder that the NFHS-3 data shows high rate of malnutrition across many states.
(http://planningcommission.nic.in/plans/planrel/fiveyr/10th/volume2/v2_ch2_1.pdf)

The per capita availability food grain is about 460 gm which is below the recommended nutritional level of 575 gm. That is one reason why about 47 per cent of our children are underweight and our infant mortality rate, at 66 per 1000, is much higher than that of our neighbours — it is 20 in Sri Lanka and 33 in China.

In a 30,00 urban population of Ludhiana, mostly from the slums, it was found over all prevalence of malnutrition, in children under five years to be 67 per cent for males and 69 per cent for females. Further, the analysis of 280 deaths in children aged 1-5 years mostly from urban slums showed that malnutrition was an associated cause in two-third of the deaths. (http://www.hansis.net/international/information/healtharticles/Urban-Health-Care-in-India.php)

Studies conducted by NIN in Jabalpur and Calcutta showed a higher prevalence of malnutrition among the children in urban areas than the rural population.

Overcrowding, lack of water and sanitation

Most urban poor live on places that are overcrowding with poor sanitary conditions, not meant for human habitation lacking facilities such as water supply, toilet facilities, and place for waste disposal. Some of these places are permanent and others are temporary. (UN Habitat, 2003)

The inadequate attention to rural development and present aggrerian crisis are deteriorating soicio economic conditions in the rural areas and force

millions of rural poor migrate to urban areas. As a result the existing slums dwellers face the problem of overcrowding in the existing places and new slums are created on place unfit for human habitation. Clogged drains, presence of rodents, lack of facilities for garbage disposal, stagnant water are common seen around the residential areas of the urban poor. Under these conditions the urban poor fall prey to many illnesses such as diarrhoea, dengue, malaira, dysentery, cholera, jaundice and typhoid, which are closely related to poor environmental conditions.

Water supply and sanitation is the major concern particularly for the poor. A study conducted by the Jansahoyg an urban resource centre in Bangalore revealed that 10 out of the 14 samples collected form water source for the urban poor were unfit for consumption.

The urban poor also suffer from inadequate or lack of toilet facilities. In many places more people have to share a single common public toilet, which is poorly maintained. About one third of the population has no access to a lavatory, while another third share a latrine. (We need reference for the data)

The growth of slums in urban areas is a manifestation of the inadequacy of basic amenities such as water supply, sanitation, electricity and other infrastructure facilities for the growing population. Lack of basic amenities in urban areas has a telling effect on the morbidity and mortality rates. Micro-level studies indicate high levels of morbidity and mortality among the slum population. Lack of sanitary and safe drinking water facilities, improper disposal of refuse and inadequate drainage system, and poor access to health facilities are some of the causes for this. (Source: http://www.undp.org.in/report/POSITION/CCA.htm)

Inadequate housing and insecure tenure of land

In slum households with one married couple, 44% of households did not have a separate room for the couple. In households with more than one couple, the problem was mo re acute. *(Source: Housing condition in India: Household amenities and other characteristics. (Source: National Sample survey organization, ministry of statistics and programme implementation. (July – December 2002)*

> The city of Delhi has its own share of nearly 3.5 million urban poor out of which as estimated 52, 765 people are homeless 90% of the homeless are productive and through their cheap labour subsidies the cities we live in. (source: http://timesfoundation.indiatimes.com/articleshow/939887.cms)

The Working Group on Housing has observed that around 90 per cent of housing shortage pertains to the weaker sections. There is a need to increase the supply of affordable housing to the economically weaker sections and the low-income category through a proper programme of allocation of land, extension of funding assistance, and provision of support services. The problem of the urban shelter less and pavement dwellers has not been given the consideration that is looked for in a welfare or pro-poor polity, as seen from the lack of progress in the programme for the Night Shelter Scheme. (Source: tenth plan approach to urban development, housing and poverty http://www.ciionline.org/sectors/61/Images/tenthplan.pdf).

The following schemes such as NSDP, SJSRY, VAMBAY, Night-Shelter, 2-Million housing scheme, AUWSP, Low-cost sanitation-etc are available from the central government for the urban poor. How easily are these schemes benefited the poorest of the poor and the neediest?

The problem of the urban pavement dwellers has not been given the consideration that is looked for in a welfare or pro-poor polity, as seen from the lack of progress in the programme for the Night Shelter Scheme. (*Source: tenth plan approach on urban development urban housing & urban poverty)*

Global Campaign for Secure Tenure

Key principles and concepts

- Housing rights for all
- Security of tenure as essential for city stability, human dignity and urban development;
- Gender equity, to ensure active inclusion of women in development;
- Partnership, as a means to ensure sustainable development through the participation of all protagonists;
- Negotiated resettlements instead of forced evictions;
- Transparent and open land markets to fight corruption and reduce speculation; and
- Land availability to meet the needs of urban poor.

The UN Commission on Human Rights in its Resolution on Forced Evictions emphasized that, "the practice of forced eviction constitutes a gross violation of human rights, in particular, the right to housing. The Commission recognized that, "instances of forced evictions occur in the name of development (and) city beautification programmes" and cautioned; "state parties shall ensure, prior to carrying out any eviction, that all feasible alternatives are explored, avoiding or at least minimizing the need to use force and see to it that all the individuals concerned have a right to compensation." *(Source: **Editorial: Nowhere to Live - Urban Housing in India,** Vol 3 Issue 3 September - October 2004, combat law)*

The Asian Human Rights Commission (AHRC) has received information about case of another forced eviction from West Bengal, India. On 15 December 2003, the Kolkata Municipal Corporation carried out a forced eviction along the canal side settlements at the Bagbazar and Cossipore area. About 1,500 families were forcefully evicted without any rehabilitation plan. It is estimated that almost 75,000 people became homeless due to this eviction.

In Mumbai 80,000 homes were demolished between December 2004 and January 2005, rendering 300,000 people homeless. For majority of those evicted there was no advance notice, the evictions were violently carried out and their belongings damaged. Those evicted were not even offered alternative accommodation. This resulted in severe criticism from various quarters; the chief minister justified the brutal demolitions as the only way to convert Mumbai into a world-class city."

WE RECOMMEND

Mapping Migration: Enhance national data collection and pool micro pieces of information from various sources to understand the scale/nature of migration

Identity & Entitlements: Institution of a Migrant Cells, registration and Identity Cards; access to Public Services; cooperation between States/ Ministries/Departments.

Labour Laws: Time-bound implementation of minimum wages, social security and maternity entitlements; industry specific new legislations with Tripartite Boards particularly with regards to safety in places of work.

Childcare Services: At worksites/through ICDS; special cadre of childcare workers; adequate budgets under current schemes/new legislations; replace "schemes" with a "per child norm" to allow flexibility; minimum wages to the worker.

Education: SSA to mainstream the migrant child; options like mobile schools, bridge courses, etc. for migrant children; enforcing the law against child marriage as necessary pre-conditions to educating girls; review of the mid-day meal scheme.

Urban health services

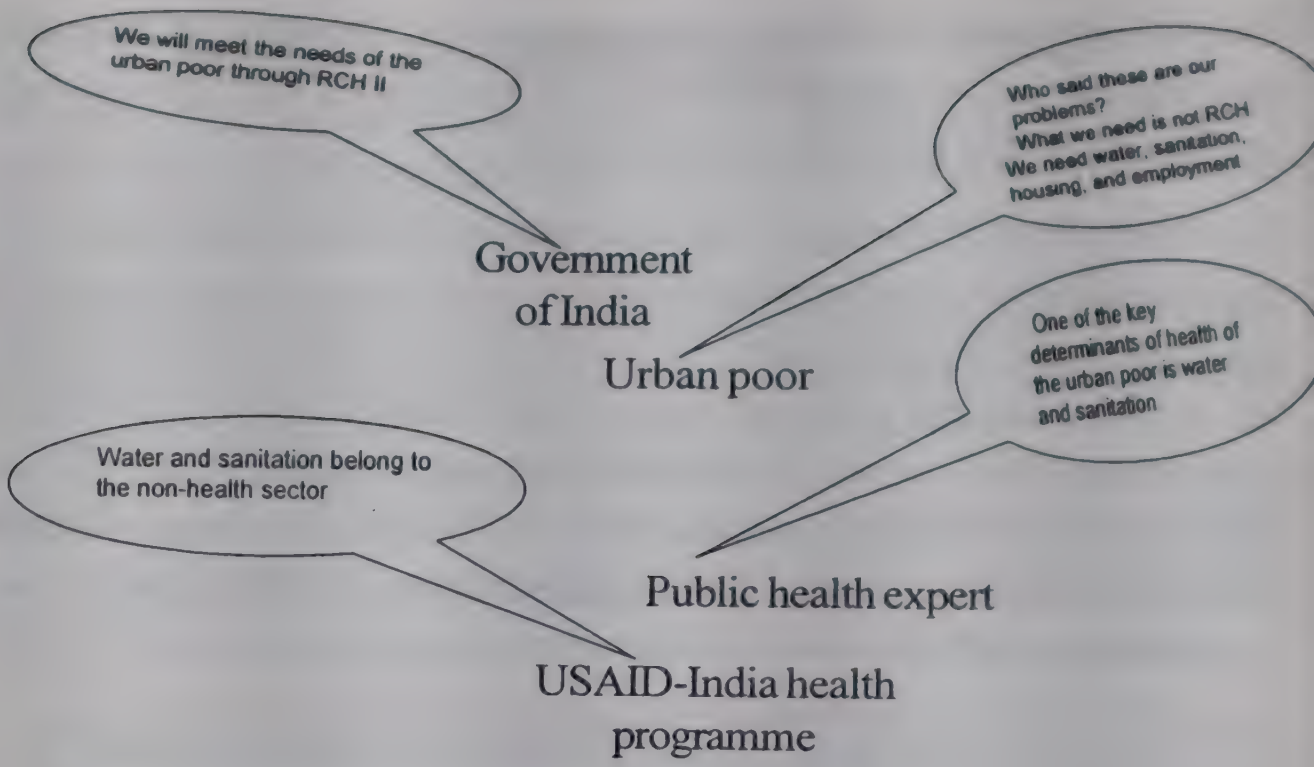
Urban areas are flooded with hospitals, nursing homes and clinic of various type and size which belong to both the public and private sector.The government of India appointed the Krishnan Committee in 1982 to address the problems of urban health. The health post scheme was devised for urban areas based on the recommendations of the Krishnan Committee. These services have been divided into outreach, preventive, family planning, curative, support (referral) services and reporting and record keeping.

Outreach services include population education, motivation for family planning, and health education. In the present context, very few outreach services are being provided to urban slums.

The Health Post (HP) scheme was launched in 1983-84. A deputy director and joint director were assigned to urban health, but functioned chiefly to promote family planning goals [Verma and Bhende 1986]. In recent tiems the health planners propose one primary health centte for 100000 population. This is agianst the Krishan committee reprot which said one center for every 50000 population. (Source: Primary Healthcare in Urban Slums by Nandita Kapadia-Kundu, Tara Kanitkar, *EPW Commentary December 21, 2002)*

> The 3,600 odd cities and towns of India with some 40 million people living in slums have to depend largely on private practitioners (mostly quacks) for their health care needs. Out of the 3,000 plus urban local bodies in India only about 100 have been some semblance to a health care service while the rest have only a sanitary inspector or even a lower functionary to look after the health care system.
>
> Sorcce:http://www.hansis.net/international/information/healtharticles/index.php

Unless there are attempts to correct the key determinants of urban Poor's health like water, sanitation, housing and employment, it is unlikely to provide a healthy life to urban poor. Unfortunately the thrust of whatever limited healthcare services provided to urban poor is with a limited focus on RCH services in order to achieve family planning services.


We will meet the needs of the urban poor through RCH II
Government of India
Who said these are our problems? What we need is not RCH We need water, sanitation, housing, and employment
Urban poor
One of the key determinants of health of the urban poor is water and sanitation
Water and sanitation belong to the non-health sector
Public health expert
USAID-India health programme

Urban health challenges and Jawaharlal Nehru Urban Renewal Mission (JNNURM)

According to the 2001 census, India has a population of 1027 million with approximately 28per cent or 285 million people living in urban areas. As a result of the liberalization policies adopted by the Government of India is expected to increase the share of the urban population may increase to about 40 per cent of total population by the year 2021. It is estimated that by the year 2011, urban areas would contribute about 65 per cent of gross domestic product (GDP). However, this higher productivity is contingent upon the availability and quality of infrastructure services. Urban economic activities are dependent on infrastructure, such as power, telecom, roads, water supply and mass transportation, coupled with civic infrastructure, such as sanitation and solid waste management. Source: 'JNNURM overview' by ministry of urban employment and poverty alleviation and Ministry of Urban Developmet.

Will the **National Urban Renewal Mission** improve the quality of live of the urban poor?

Big promises come with big conditionality

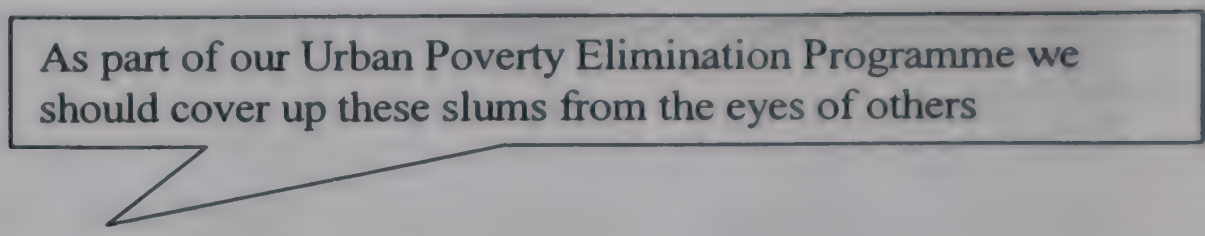
The process of drafting the mission was highly influenced by corporate interests in real estate, construction, transport and urban service sector lobbies. The entire Mission formulation and related actions have been orchestrated by agencies such as the World Bank and USAID which have a vested interest and long history of promoting neo-liberal developmental policies which include privatisation of water, electricity etc.

Mandatory Reforms for cities wishing to avail of NURM assistance are:

- Drawing up public-private-partnership (PPP) models for development, management and financing of urban infrastructure
- Introduction of independent regulators for urban services
- Rationalization of stamp duty to no more than 5 per cent within five years.
- Repeal of the Urban Land Ceiling and Regulation Act
- Reform of rent control laws to stimulate private investment

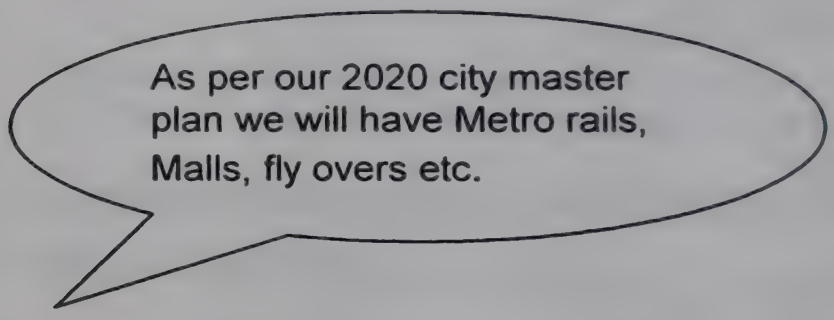
Five Optional Reforms are also to be "freely" chosen from a list that includes VRS Schemes, Non-filling of vacant posts, revision of by-laws governing building construction, simplifying conversion of agricultural land for non-agricultural purposes.

Theses condtionalties will be implemented with the help of tool Model Municipal Law (MML developed by Ministry of Urban Development with the sponsorship of USAID. The Delhi Municipal Corporation has already adopted and brought in changes in building by laws and privatizing water.



Government Official

This Mission has the threat of trapping us under the liberalized, privatized multinational corporation's vested interest. If the conditions are allowed, it will undermine the democratic process of achieving health and development. Therefore we should oppose all conditionaliteis.



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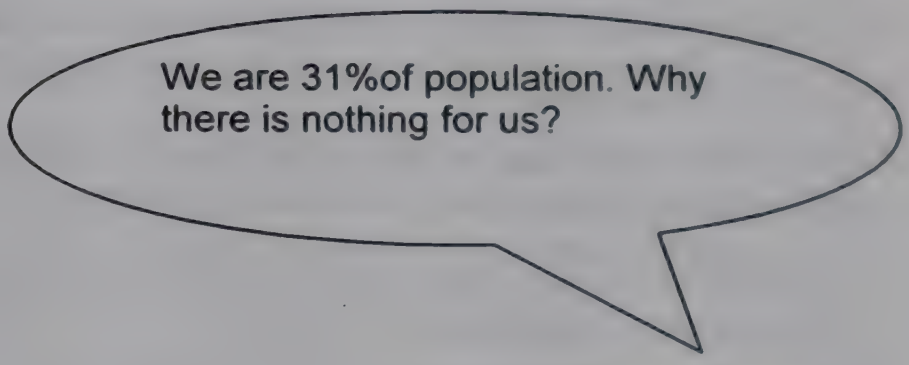

Urban poor

In view of the above concerns we propose

- Adequate attention should be given to rural development so that the rural popluation do not migrate to urabn areas for livelyhood.
- When the rural poor are brought to urabn areas by the contractors of the construction industry, ensure basic necessties are not comopromised. Formulate standards of habitation that will ensure basiec ameneties sucah as housing, water and sanitation.
- Wherever slums/informal settlements are classified as Tenable, the ULB must facilitate the granting of tenure on all government occupied land and initiate acquisition proceedings and/ or negotiations on all privately occupied land in accordance with Section C.5 of the Draft Slum Policy
- Recognize the slums that are in exisitence for more than 5 years.
- There is a need to increase the urban infrastructure for health at all levels including big cities and small towns to cope with the growing urban population.
- Posts need to be created at various levels within the health department to ensure coordination, monitoring and review of all municipal bodies;
- All health posts should provide outreach services to slum and slum-like areas through the ANM and MPW;
- The recommendation of the Krishnan committee for a community health worker for population of 2,000 should be put into place;
- Ward committees should monitor and demand primary healthcare services from the health post system.
- There should be an intersectoral committee for public health for all municipal bodies.

- The provision of basic amenities for slum and slum like populations is required.
- Special provisions should be made for providing health services to pavement dwellers and temporary settlements.
- New guidelines on the role and functioning of the health post system in view of an integrated and decentralised primary healthcare programme need to be developed and implemented uniformly across all the municipal bodies in the state; There needs to be integration of all vertical programmes (such as TB, malaria, HIV/AIDs) with the primary healthcare system in urban areas.

* * *

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